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STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION

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APPLICATION FOR LICENSE AS A RESPIRATORY CARE PRACTITIONER IN THE STATE OF DELAWARE

I am applying for licensure by way of:

_____ Initial Licensure

_____ Reinstatement

SECTION I: PERSONAL INFORMATION

Name: _____
(Last Name) (First Name) (Middle/Maiden)

Mailing Address: _____
(Street/P.O. Box)

_____
(City) (State) (Zip Code)

Home Telephone: _____ Work Telephone: _____

Email Address: _____ Date of Birth: _____

Social Security Number: _____

SECTION II: EDUCATIONAL INFORMATION

Respiratory Care Practitioner Education:

School	Location	Dates Attended	Degree

_____

_____

CONTINUE TO PAGE 2

Pursuant to Section 7 of the Privacy Act of 1974, you are hereby given notice that the disclosure of your social security number on this application is required by 29 *Del. C.* §8735(m). It may be used to enforce child support obligation pursuant to 13 *Del. C.* §2216 and for other lawful purposes.

SECTION III: LICENSURE / PRACTICE

1. Have you ever sought or been granted a respiratory care practitioner license under another name? Yes ( ) No ( )

If yes, indicate other name(s) used:

_____

2. Have you successfully completed the National Board for Respiratory Care, Inc. (NBRC) Entry Level Exam / Certified Respiratory Therapist (CRT) Exam? Yes ( ) No ( )

If yes, please have the NBRC provide verification of credentials directly to the Board of Medical Practice.

3. Have you ever been convicted of or entered a plea of guilty or nolo contendere (no contest) to any felony, misdemeanor or any other criminal offense in any jurisdiction? Yes ( ) No ( )

If yes, please explain and indicate any other name(s) used:

_____
_____
_____
_____

4. Are there any pending disciplinary actions or complaints against you before any body that regulates the practice of respiratory care? Yes ( ) No ( )

If yes, please explain circumstances and outcome:

_____
_____
_____

5. Have you ever had a respiratory care practitioner license denied, revoked, suspended or limited or placed on probation? Yes ( ) No ( )

If yes, please explain circumstances and outcome:

_____
_____
_____

6. Have you ever been granted licensure as a Respiratory Care Practitioner by a State or Territory?

Yes ( ) No ( )

6. (continued) If yes, please list the following as indicated below:

State or Territory	License Number	Expiration Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. Is this application for licensure based on reciprocity? Yes ( ) No ( )

If yes, on a separate sheet provide a list of the qualifications for licensure from the state which granted the license.

SECTION IV: HEALTH AND DISABILITY

1. Have you recently or within two years had a physical or mental disability which could reasonably be thought to interfere with your practice as a respiratory care practitioner, including use or abuse of dangerous or addicting substances? Yes ( ) No ( )

If yes, please explain on a separate sheet and attach to this application.

2. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? Yes ( ) No ( ) Not applicable ( )

If yes, please explain on a separate sheet and attach to this application.

3. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? Yes ( ) No ( ) Not applicable ( )

If yes, please explain on a separate sheet and attach to this application.

SECTION V: LEGAL AND BEHAVIORAL

1. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense in any jurisdiction? If yes, submit a certified copy of your criminal history record. Yes ( ) No ( )

2. Have you ever been disciplined by a healthcare facility or any entity governing respiratory care licensure? Yes ( ) No ( )

If yes, please explain on a separate sheet and attach to this application.

The Board office must receive items submitted for the Board to consider at its meeting no later than two full business days before the meeting. In order to be considered at a Board meeting, license applications must be complete two full business days before the meeting. A complete application is one that includes all required documentation and correct payment.

Applications that are not complete within six (6) months of filing may be considered abandoned and discarded. The Board office will attempt to notify you before disposing of an abandoned application.

Please note: When your application is complete, please allow 4-8 weeks to receive your permanent license (whether or not a temporary license has been issued).

SECTION VI: AFFIDAVIT

I, _____, swear that I am the person who executed this application; that the statements contained on this application are true in every respect; that I have not suppressed or withheld information that might affect this application; and I will abide by the laws and the ethical standards of this profession; and that I have read and understand this statement.

I further understand that by filing this application for a Respiratory Care Practitioner in the State of Delaware, I hereby authorized and consent to have an investigation conducted to determine my professional qualifications, to determine if I have previously engaged in unprofessional conduct as defined in 24 Delaware Code §1731 or the Rules and Regulations of the Delaware Board of Medical Practice and to determine that I am physically and mentally capable of engaging in the practice of respiratory care with safety to the public.

I authorize and request every person, hospital, clinic, community, governmental agency (local, state, federal or foreign), court, association, institution or other organization having control of any documents, records or other information pertaining to me, to furnish to the Delaware Board of Medical Practice any such information, including document, records regarding charges or complaints filed against me, formal or informal, pending or closed, other pertinent data and to permit the Delaware Board of Medical Practice or any of its agents or representatives to inspect and make copies of such documents, records, and other information, in connection with this application, subsequent licensure or practice thereunder.

_____ _____

Signature of Applicant Date

Sworn to before me and subscribed in my presence this _____ day of _____

20____, County of _____ State of _____

My commission expires:_____ _____

Notary Public

SECTION VII: APPLICATION FOR TEMPORARY PERMIT

I wish to receive a **temporary permit** after the Delaware Board of Medical Practice has received all of the required documentation and determined I have met the licensure requirements.

☐ YES ☐ NO

Signature of Applicant _____ Date _____